



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
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To Report Adult Abuse: (800) 564-1612  
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July 19, 2011

Jessica Jennings, Administrator  
Saint Albans Healthcare And Rehabilitation Center  
596 Sheldon Road  
Saint Albans, VT 05478

Provider #: 475021

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the revisit survey conducted on **June 28, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

Enclosure



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 Division of  
 JUL 18 11

 PRINTED: 07/13/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475021	(X2) MULTIPLE CONSTRUCTION Licensing and Protection A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 06/28/2011
NAME OF PROVIDER OR SUPPLIER  SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS	{F 000}			
{F 253}	<p>SS=E</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and confirmed through interview, the facility failed to assure that all resident areas were maintained in a sanitary and comfortable manner. Findings include:</p> <p>During the re-visit tour of the physical environment on the morning of 06/28/11, the following observations were made:</p> <p>1. There was crumbled paint, and/or loss of sheet rock exposing interior wall board, on the walls behind the toilets in the bathrooms of rooms #11, #18, #24 and #25 on the East Wing. The deteriorated areas of wall were centered around plumbing fixtures and located directly below the faucet handles.</p> <p>2. The Resident shower room located on the West Wing had tile missing from the corner wall between the 2nd and 3rd shower stalls.</p> <p>Per interview at 2:00 PM the Administrator stated that they had received a quote at in May from a</p>	<p>F253</p> <p>{F 253}</p> <p>St. Albans Health &amp; Rehab Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Residents on the East Unit rooms #11, #18, #24, And # 25 have the potential to be affected by this deficient practice.</p> <p>B&amp;D Construction, have already sheet rocked the walls behind the toilets in the mentioned rooms, and will begin painting them the week of 7/18/11.</p> <p>Abel Glass &amp; Tile will be at the center the week of July 18<sup>th</sup>, 2011 to replace the tile in the west wing shower room.</p> <p>Environmental rounds will be completed Weekly x 90 days by the Maintenance Department to assure all resident areas are maintained in a sanitary and comfortable manner. Audits will be reviewed during the quarterly QA meetings.</p> <p>Corrective Action completed by July 25, 2011.</p> <p>F253 POC Accepted 7/18/11 Semmons RN / Administrator</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/13/2011  
FORM APPROVED  
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{F 253}	Continued From page 1 contractor and also approval from their corporate office recently for payment. The Administrator confirmed that the above mentioned areas are not in good repair and were not fixed.	{F 253}		